EYE SURGERY CENTER
OF NORTH DALLAS

PATIENT NOTIFICATION & ACKNOWLEDGEMENT

Patient Sticker

Name DOB

Surgeon DOS

Notice of Rights

Eye Surgery Center of North Dallas has established a Patient's Bill of Rights, which is provided verbally and in writing in a language and manner the patient or patient's representative understands prior to the date of the procedure. Eye Surgery Center of North Dallas expects that observance of these rights will contribute to more effective patient care and greater satisfaction for patients, physicians and the facility.

Financial Disclosure

Eye Surgery Center of North Dallas is privately owned and has informed the patient prior to the date of the procedure that their physician may have a proprietary interest in this facility. The patient has the right to choose the facility of his/her choice for health related services.

Advance Directives

Because the scope of Eye Surgery Center of North Dallas is limited to elective outpatient surgical procedures, it is the policy of this facility, that any life-threatening situation that arises will be immediately treated with life-sustaining measures. Concurrently, the emergency medical system (EMS) will be activated for emergency patient transport to a hospital facility. The patient's right and need to be an active participant in the decision making process regarding their care is recognized and respected. Acknowledgement of this policy does not revoke or invalidate any current health care directive or health care power of attorney.

Please check the appropriate box. Have you executed an advance health care directive, a living will and/or a power of attorney that authorizes someone to make health care decisions for you?

- ☐ **Yes**, I have an advance health care directive, living will and/or a power of attorney.
- ☐ **No**, I do not have an advance health care directive, living will and/or a power of attorney.
- ☐ I would like additional information on advance health care directives.

By signing this document, I acknowledge that the above information was given to me prior to my day of surgery, and that I have read and understand the information on notice of privacy practices, patient rights, financial disclosure and advance directives. I agree to the policies of Eye Surgery Center of North Dallas. If I have indicated I would like additional information, I acknowledge receipt of that information.

_____ _____

Patient Signature (If patient is unable to sign, please indicate relationship) Date

_____ _____

Witness Signature Date

EYE SURGERY CENTER
OF NORTH DALLAS

PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Sticker

Name DOB

Surgeon DOS

By signing this form, you acknowledge that you have been informed that Eye Surgery Center of North Dallas provides information about how we may use and disclose your Protected Health Information (PHI). We encourage you to read the "Notice of Privacy Practices" posted in our lobby. If you would like a paper copy, please ask the receptionist.

Eye Surgery Center of North Dallas may use the following methods of communication regarding information related to my personal health, treatment or payment for treatment. I acknowledge I am responsible for updating this information as necessary. This request supersedes any prior request for methods of communication I may have made.

☐ Contact me by phone at home _____

☐ Work _____ ☐ Cell _____

☐ ESCND may leave a message on my voice mail/answering machine

☐ ESCND may speak to anyone who answers the phone

☐ ESCND may only speak to _____

☐ ESCND may leave a message for me at my work phone number

Questions or concerns about our Privacy Notice or Practices should be directed to the Privacy Officer at (972) 380-2020.

Signature_____ Date_____
(Patient/Parent/Conservator/Guardian) (Mo/Day/Yr)

Inability to obtain acknowledgement: *To be completed only if no signature is obtained:*

☐Patient lacks the ability to understand the Notice of Privacy Practices

☐Other_____

Signature_____ Date_____
(Provider Representative) (Mo/Day/Yr)

EYE SURGERY CENTER
OF NORTH DALLAS

FINANCIAL AGREEMENT
ASSIGNMENT OF BENEFITS

Patient Sticker

Name DOB

Surgeon DOS

I hereby assign to Eye Surgery Center of North Dallas (collectively, the "Center") all insurance benefits or unemployment compensation disability benefits otherwise payable to me for treatment. I acknowledge that I am financially responsible for paying the Center for services rendered in accordance with the regular rates and terms of this facility to the extent that the relevant insurer, plan or payer does not pay the Center for such services in full. This assignment of benefits is irrevocable with respect to any services performed by the Center before I have given written notice of my decision to rescind this agreement.

I acknowledge that I am obligated to pay the Center any monies I receive directly from an insurer for services for which the Center has not yet been paid in full. I agree to pay such monies to the center within seven (7) days from the date I receive payment. I further agree to provide the Center with a copy of the insurer's Explanation of Benefits form along with the payment rendered from the insurer.

I recognize that the physicians and surgeons furnishing services, including pathologists, anesthesiologists, and the like, are independent contractors and are not employees or agents of the Center, and that, as a result, the services they provide will be billed by each of them independent of the Center. In addition, ancillary services, such as x-ray examinations, laboratory procedures and medications will also be billed by each such service independently.

Should my account be referred to an attorney or licensed collection agency, I will be required to pay reasonable attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal interest rate.

I hereby authorize all doctors, this facility or other institutions rendering care and treatment to furnish the responsible parties and/or insurance companies with full information regarding treatment rendered (including copies of their records). A photocopy of this authorization shall be considered as effective and valid as the original.

The undersigned certifies that he/she has read the foregoing, receiving a copy thereof, and accepts the terms.

_____ _____

Signature Printed Name /Date

_____

Witness/Date

If not signed by the patient, please indicate relationship:

( ) parent or guardian of minor patient
( ) guardian or conservator of patient
( ) spouse or person financially responsible
( ) other; please specify _____